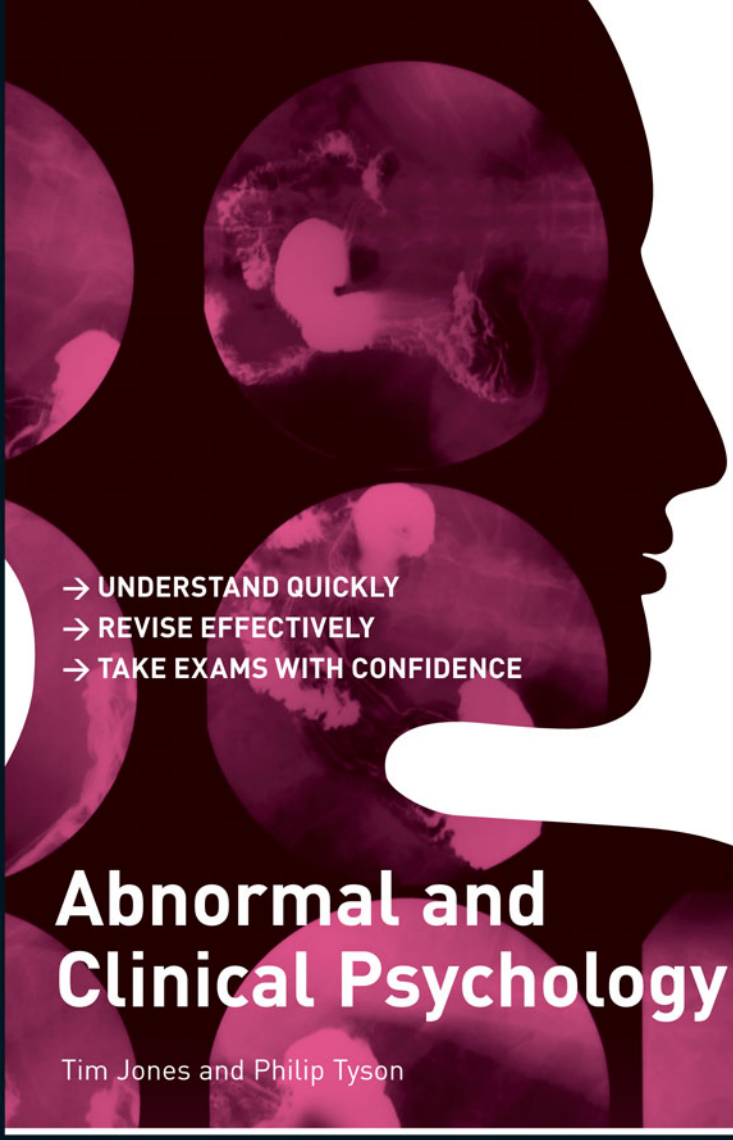

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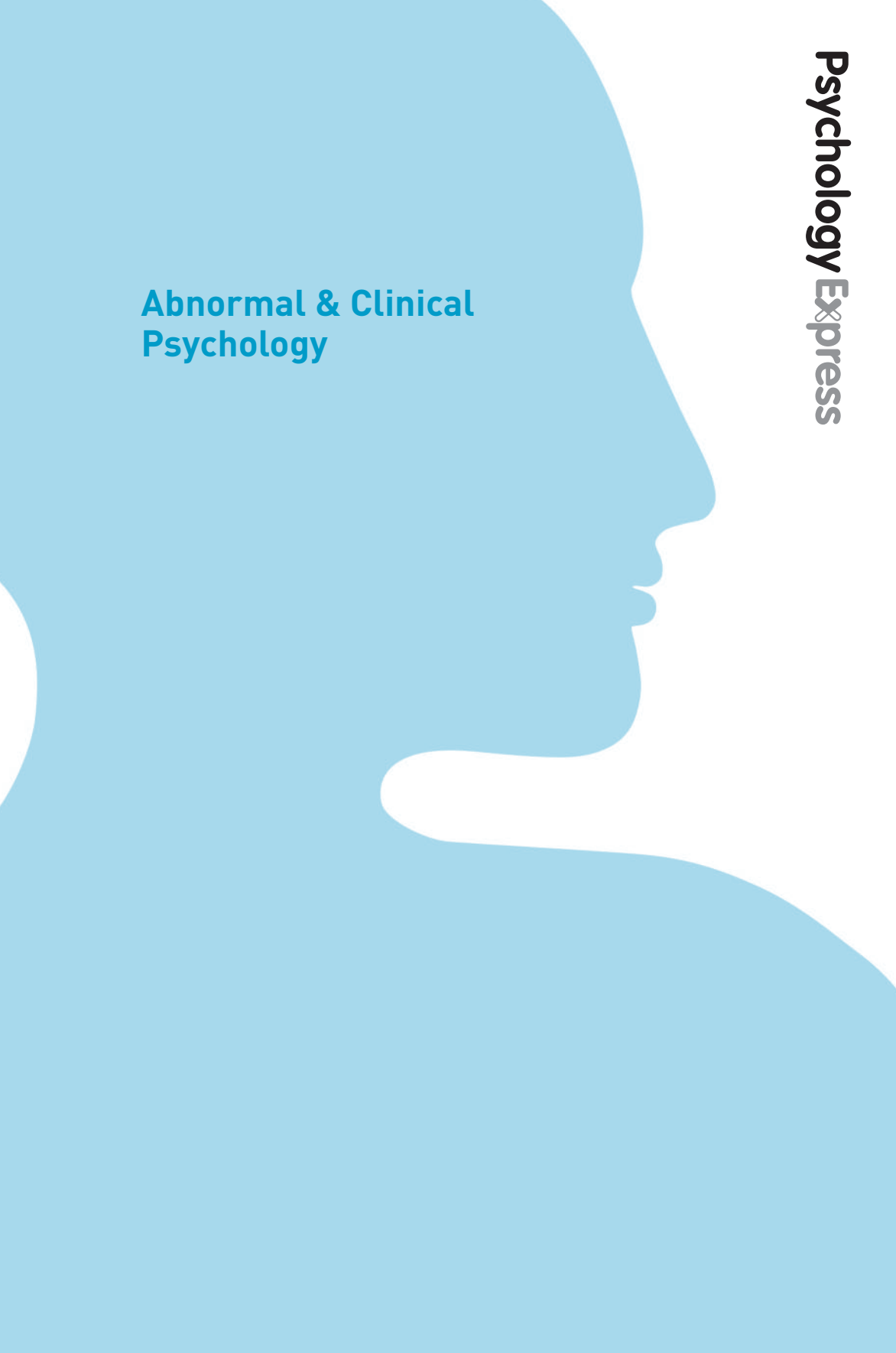

situation followed by the suffix 'phobia'. So, for example, the Greek word for spider is *arachne* and therefore a phobia for spiders is called *arachnophobia*. *Claustrophobia* derives from the Latin word for an enclosed space *claustrum* and describes a fear of confined spaces. Other examples of phobia names are presented in Table 4.1.

Table 4.1 Five phobias

Fear of	*Name*
Blood	Haematophobia
Germs	Microphobia
Heights	Acrophobia
Snakes	Ophidiophobia
Water	Aquaphobia

There is inconsistency in the literature as to which is the most common specific phobia. Depla, ten Have, van Balkom and de Graaf (2008) reported that fear of heights was the most prevalent, affecting 4.9% of the general population, whilst Oosterink, de Jongh and Hoogstraten (2009) found dental phobia to be the most common (3.7%), with phobia of heights the second most prevalent (3.1%) and spider phobia third (2.7%). Females appear to be at greater risk of specific phobia than men (21% vs. 11%), with women having greater prevalence of animal phobia (12% vs. 3%) and situational phobia (17% vs. 8%) than males although no gender difference was evident for the blood–injection–injuries subtype (Fredrikson et al., 1996).

Social phobia

Sometimes termed *social anxiety disorder*, social phobia is a condition where an individual has an intense and persistent fear of being under scrutiny or embarrassing themselves in social situations. For example, a middle-aged lady may hate going shopping because she fears everyone will be looking at her and if she is engaged in conversation in a shop or at the checkout she worries that she will stutter and make a fool of herself. This fear prevents her from going shopping. Social phobia has a lifetime prevalence of 12.1% (Kessler et al., 2005) with fears relating to meeting new people, speaking in public or using public bathrooms being most common (APA, 2011). Individuals with social phobia have negative opinions about themselves and the possible outcomes of social situations. For example, Wells et al. (1995) report the case of a lady who was afraid of walking into crowded shops because she thought she would collapse and people would stare at her. In order to relieve her anxiety about collapsing, this lady would lean on things in the shop, sing to herself and avoid the eye contact of others. These anxiety-relieving strategies are called *safety behaviours.*

CRITICAL FOCUS

Social phobias and safety behaviours

Situation	*Fear*	*Safety behaviour*
Talking to strangers	Babbling	Speak quickly, take deep breaths, rehearse sentences
Drinking in front of others	Losing control	Use both hands, grip cup tightly, move slowly
Reading to a group	Shake uncontrollably	Try to avoid holding the book, turn pages slowly, take deep breaths
Eating in public	Vomiting	Eat small amounts, nibble, drink water

Adapted from Wells et al. (1995).

The acquisition of phobias

Biological perspectives

Twin studies have suggested a heritability of between 35 and 45% for phobias overall (Hettema, Annas, Neale, Kendler, & Fredrikson, 2003). Other biological theories have emphasised the heightened sensitivity of brain regions involved in the fear network, such as the amygdala, medial prefrontal cortex and thalamus. For example, these areas have been found to be highly active when spider phobics have been shown pictures of spiders (Schweckendiek et al., 2011). Several neurotransmitter systems are also thought to be involved in phobias, particularly serotonin (Stein & Stahl, 2000).

An interesting evolutionary perspective suggests that we all have an innate tendency to be afraid of certain animals and situations which stems from the danger that these things have held for us in the past. For example, our fear of snakes and heights has been evolutionarily advantageous as our fear prevents us being exposed to potentially harmful situations (Öhman & Mineka, 2001). This preparedness theory has some support as both humans and monkeys do appear to have a very quick visual detection system for potentially threatening animals in the environment such as snakes and spiders (Shibasaki & Kawai, 2009; Soares, Esteves, Lundqvist, & Öhman, 2009). However, this theory would have great difficulty explaining some of the phobias associated with modern living, such as fear of elevators or costumed characters.

Key term

Preparedness theory: suggests that humans have an innate tendency to be afraid of certain objects or situations that could potentially cause us harm, e.g. snakes or heights. By avoiding these things, we have a better chance of survival. This theory is one explanation for the acquisition of phobias and contrasts with other theories which suggest phobias can be learnt.

Psychological perspectives

Some phobias appear to be acquired through the process of classical conditioning where the phobic stimulus has been paired with a frightening event (Öst, 1987). This theory was illustrated in the classic study by Watson & Rayner (1920) where they conditioned Little Albert to be scared of a white rat and also in the case study of Bagby (1922) where a girl developed a phobia for water after having a terrifying experience in a waterfall (see Chapter 2). More recently, Jacobson et al. (1995) was able to condition fear and nausea in response to a beverage in a distinctive container (lemon-lime Kool-Aid) after repeated pairings of the beverage to the chemotherapy treatment that a group of women were undergoing.

However, not all phobias stem from classical conditioning and some people develop phobias after seeing someone else show a fear of an object or situation (e.g. a child observers her mother panic when a wasp is close). This type of learning is called *modelling* or *observational learning* and there is some empirical support for phobias originating in this way. For example, one study found that children copied the anxious behaviour of their parents prior to a spelling test (Burstein, Ginsburg, & Tein, 2010) whilst Broeren et al. (2011) reported that children imitated the calm or anxious behaviours shown towards animals by their peers. Rhesus monkeys have also been found to acquire fears by observing fearful behaviours in other monkeys (Mineka & Cook, 1986).

From an informational perspective there is the suggestion that phobias can originate when individuals are given *negative information* about an object or situation (Rachman, 2002), such as in the study by Muris, van Zwol, Huijding and Mayer (2010) where children who were given frightening information about an animal ('it can jump at your throat') were more fearful of it than those who were given neutral or positive information. Studies have also emphasised the important role that parents play in creating fear in their children through passing on negative information about animals (Remmerswaal, Muris, Mayer, & Smeets, 2010).

Several studies have considered the key competing psychological explanations for the development of phobias by asking phobics about the origins of their fears (e.g. Ollendick & King, 1991). Explanations relating to *classical conditioning, modelling* and the influence of *negative information* have all been reported in these studies but it appears that the three possible routes of phobia acquisition may interact with each other and that different types of fears may have distinct origins (Coelho & Purkis, 2009). However, each of the main theories of the acquisition of phobias have been criticised (see Coelho & Purkis, 2009 for a review).

Agoraphobia

Agoraphobia literally means fear of the market place but in contemporary clinical terms it describes a fear of being in places including: outside of the home alone, in small crowded places or wide open spaces, shops, cinemas, and on public transport. However, the fear is not about these places per se; rather, the fear is of the individual having a panic attack in these situations and there being no

escape route or there would be no-one to help if this happened. Agoraphobia is considered to be related to panic disorder because the overriding fear is of having a panic attack in specific situations (for a review see Perugi, Frare, & Toni, 2007). The lifetime prevalence of agoraphobia with panic attacks is 8% (Kessler et al., 2006) but agoraphobia alone is much less frequent at 1.4% (Kessler et al., 2005). This disorder is more frequent in women than in men and it usually begins between the ages of 15 and 35 years and it can persist for years if left untreated.

Treatments for phobias

Biological-based treatments

Biological-based treatments for phobias almost exclusively involve the use of pharmacological agents to alter neurotransmitter systems. Antianxiety medication (also known as anxiolytics) such as the benzodiazepines (e.g. Lorazepam, Diazepam) have been found to reduce anxiety in social phobia (Davidson, Tuppler, & Potts, 1994) and specific phobia (Thom, Sartory, & Jöhren, 2000). Antidepressant medication, particularly the selective serotonin reuptake inhibitors (SSRIs), have shown considerable success in treating social phobia (Schneier, 2001) but not specific phobia.

Psychological-based treatments

Psychological techniques to treat phobias tend to focus on the emotion, cognition and behaviour associated with phobias.

Emotion

Being afraid can be an unpleasant experience during which we may sweat, tremble, have shortness of breath, increased heartbeat and sometimes nausea. Individuals with phobias will experience such symptoms in the presence of the feared stimulus and one of the goals of psychological treatment for phobias would be to reduce this physiological reactivity using somatic control exercises. These primarily include techniques to help the phobic relax and regulate their breathing as outlined by Kearney and Trull (2012):

- *Relaxation training*. Here the phobic is taught how to relax, such as in progressive muscle relaxation techniques where the client is asked to tense, and then relax, different muscle groups (e.g. shoulders, stomach) sequentially. The purpose of this is to assist the client in recognising when they are tense and anxious and also teach them how they can control their physical tension. This technique has proved successful at reducing reactivity to phobic stimuli, such as in the study by Lundgren, Carlsson and Berggren (2006) who used it to reduce dental fear.
- *Breathing retraining*. When exposed to a phobic stimulus some individuals will hyperventilate (breathing becomes quicker and deeper) and this will contribute to their physiological reaction and state of fear. The purpose of breathing retraining is to reduce these irregular breathing patterns and this technique has been shown to reduce phobic reactivity (e.g. Bonn, Redhead, & Timmons, 1984).

Cognition

Faulty thinking patterns are a well-established feature of phobias, with individuals tending to have an attentional focus on fear-related stimuli. For example, spider phobics have been shown to be exceptionally quick at identifying spider-related images compared with images of other animals (Mogg & Bradley, 2006). In addition, phobic individuals tend to overestimate the chances of the phobic stimulus causing them harm, such as in the study by Jones & Menzies (2000) who found that spider phobics think they have a high likelihood of being bitten by spiders, and that injuries received will be very serious. Similarly, Coelho and Purkis (2009) suggest that someone with acrophobia may believe there is a high likelihood of them having a fatal fall if they are at the top of a staircase.

Cognitive therapy for phobias will involve identifying and challenging these faulty cognitions so that the individual can think more rationally about the phobic stimulus and potential outcomes of coming into contact with it (see Chapter 2 for further details of the cognitive approach). Cognitive therapy has been found to successfully amend phobic beliefs such as in the study by Kamphuis and Telch (2000) where claustrophobic individuals were enclosed in a dark chamber and asked to cognitively appraise their likelihood of harm. However, it appears that cognitive therapy alone may not be superior to exposure based, or combined therapy (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008).

Behaviour

Several therapeutic techniques exist to alter the maladaptive behavioural patterns seen in phobia:

- *Exposure-based treatment*. Here the phobic is repeatedly exposed to the feared object or situation until they learn that there is nothing to fear and the phobia is extinguished. An important element of this treatment is that there is a graded exposure to the feared object or situation with very limited exposure at the beginning of therapy which increases as treatment progresses. Recently, exposure-based treatment has taken advantage of technological advances to create virtual reality exposure therapy where phobics are exposed to a virtual reality representation of the feared stimulus. For example, fear of flying has been found to be successfully treated using a head mounted display which gave the phobics a visual and auditory recreation of flying (e.g. Maltby, Kirsch, Mayers, & Allen, 2002).
- *Systematic desensitisation*. This technique is a form of exposure-based treatment although here the phobic is taught relaxation techniques to pair with the presentation of the feared stimulus or environment. For example, Lang and Lazovik (1963) successfully treated snake phobia by gradual exposure to a live snake combined with learning relaxation techniques when exposed to the feared stimulus. Phobia for dentists and school has also been treated in a similar way (Houlihan & Jones, 1989; Shaw & Thoresen, 1974).
- *Flooding and implosion therapy*. These techniques are also forms of exposure-based treatments which are based on the presentation of the feared stimulus. In flooding the presentation of the feared stimulus is done without relaxation

training and with little preparation. The idea here is that the client would quickly learn that the phobic stimulus is not harmful. This therapy might involve someone with a phobia for dogs being introduced to a dog, or in the case of a women with a phobia for uncooked meat, exposed to a piece of raw pork (Baum & Poser, 1971). In *implosion therapy* the client is asked to visualise fear-provoking situations involving the phobic stimulus. As the fear response cannot be sustained indefinitely, after repeated fearful imaginings the phobic will habituate to the phobic stimulus and no longer feel fear. This technique was used successfully with a school-phobic 13-year-old boy who was asked to imagine many frightening scenarios at school (e.g. he is dragged onto the stage in the main hall by the headmaster with all pupils and teachers laughing at him: Smith & Sharpe, 1970).

Cognitive Behavioural Therapy (CBT), which involves the identification and modification of problematic thoughts and behaviours and utilises elements of the cognitive and behavioural approaches above, may also be used as a treatment for phobias. Furthermore, another important part of therapy may also involve psychoeducation which involves educating the individual about their phobia so they understand the link between their irrational thoughts, behaviours and emotions. For example, someone with a fear of spiders may be taught about all the different species and how very few are harmful to people.

Key term

Psychoeducation: the provision of knowledge and training about a particular disorder in order to facilitate better understanding and recovery. For example, clients may be taught to recognise symptoms indicative of a reoccurrence of an illness, or how to reduce stress.

Test your knowledge

4.1 What are the most common types of phobias?

4.2 Why might a middle-aged lady with social phobia dislike going shopping?

4.3 Give an example of how a phobia might be acquired through observational learning.

4.4 What happens during relaxation training?

Answers to the questions can be found on the companion website at: **www.pearsoned.co.uk/psychologyexpress**

Further reading Phobias

Key reading

Coelho, C. M., & Purkis, H. (2009). The origins of specific phobias: Influential theories and current perspectives. *Review of General Psychology, 13*(4), 335–348.